

1 Hon. Robert S. Lasnik  
2 Trial Date: March 2, 2020  
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5

6 **UNITED STATES DISTRICT COURT**  
7 **WESTERN DISTRICT OF WASHINGTON**  
8 **AT SEATTLE**

9 PAULETTE BECK, as Personal  
10 Representative of the ESTATE OF PIPER  
11 TRAVIS, deceased, and PAULETTE and  
12 GREGORY BECK, individually,

13 Plaintiffs,

14 v.

15 SNOHOMISH COUNTY, a municipal  
16 corporation, TY TRENARY, MAGELLAN  
17 ANDERSON, EMERSON YABUT,  
18 CONNER SMITH, BIK-YEE URBAN,  
19 KARIN HEUSTED, JASON BURNS,  
HEALTH PROS NORTHWEST, INC,  
JEANNE DUNHAM, JOSEPH KING, and  
JOHN DOES 1-10,

20 Defendants.

21 No. 2:18-cv-01827-RSL

22 **[PROPOSED] ORDER GRANTING**  
**MOTION TO ALLOW PLAINTIFFS**  
**TO FILE THEIR FIRST AMENDED**  
**COMPLAINT FOR DAMAGES AND**  
**STIPULATED/JOINT MOTION TO**  
**CONTINUE TRIAL AND RELATED**  
**DATES**

23 **NOTED FOR CONSIDERATION:**  
24 **August 7, 2019**

25 This Court having reviewed the Stipulated Motion to Allow Plaintiffs to File Their First  
Amended Complaint for Damages and Stipulated/Joint Motion to Continue Trial and Related  
Dates, and good cause appearing therefore:

26  
27  
28  
29 **[PROPOSED] ORDER GRANTING MOTION TO ALLOW PLAINTIFFS**  
**TO FILE THEIR FIRST AMENDED COMPLAINT FOR DAMAGES AND**  
**STIPULATED/JOINT MOTION TO CONTINUE TRIAL AND RELATED**  
**DATES**

*Beck, et al. v. Snohomish County, et al.*, Case No. 2:18-cv-01827-RSL  
Page 1 of 4

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1 IT IS HEREBY ORDERED:

2 1. Plaintiffs are granted leave to amend and file their First Amended Complaint for  
3 Damages, a copy of which is attached hereto as Exhibit 1.

4 2. Defendants' responsive pleading shall be due thirty (30) days from when the First  
5 Amended Complaint for Damages is filed.

6 3. The Court shall issue an Amended Minute Order continuing the trial date and  
7 related dates approximately 90 days.

8 4. The First Amended Complaint for Damages is deemed filed as of the date this  
9 Order is transmitted via the CM/ECF system.

10

11 IT IS SO ORDERED.

12

13

DATED: August 8, 2019

*Robert S. Lasnik*

14  
15 Hon. Robert S. Lasnik  
16 United States District Court Judge  
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**[PROPOSED] ORDER GRANTING MOTION TO ALLOW PLAINTIFFS  
TO FILE THEIR FIRST AMENDED COMPLAINT FOR DAMAGES AND  
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**EXHIBIT 1**

**UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE**

PAULETTE BECK, as Personal Representative of the ESTATE OF PIPER TRAVIS, deceased, and PAULETTE and GREGORY BECK, and TAMARA CASH, individually,

No. 2:18-cv-01827-RSL

## **FIRST AMENDED COMPLAINT FOR DAMAGES**

**Plaintiffs,**

SNOHOMISH COUNTY, a municipal corporation, TY TRENARY, MAGELLAN ANDERSON, EMERSON YABUT, CONNER SMITH, BIK-YEE URBAN, KARIN HEUSTED, JASON BURNS, HEALTH PROS NORTHWEST, INC, JEANNE DUNHAM, JOSEPH KING, STUART ANDREWS, and JOHN DOES 1-10,

#### Defendants.

J.

## NATURE OF THE CASE

This is a civil rights case arising out of the unnecessary and unconscionable suffering and death of Piper Travis, a 34-year-old woman who was detained for eleven days at the Snohomish County Jail, awaiting trial on misdemeanor allegations.

**FIRST AMENDED COMPLAINT FOR DAMAGES**  
*Beck, et al. v. Snohomish County, et al., Case No. 2:18-cv-01827-RSL*  
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1 While in the custody and care of the Defendants, Piper became ill with pneumococcal  
2 meningitis, an aggressive, painful, and potentially deadly central nervous system infection.  
3 For days, Snohomish County Jail deputies and nurses ignored Piper's pain and suffering.  
4 Their inaction was deliberate, inhumane, and cruel. They offered Piper no treatment for her  
5 pain. They conducted no meaningful medical or mental health assessment. They collected no  
6 background records, history, or information. They identified no probable diagnosis. They  
7 simply ignored Piper as she slowly and painfully decompensated before them. Over the  
8 course of days, Piper's moaning in pain progressed to yelling, then screaming, then  
9 incoherent speech. Piper's writhing on the floor of her cell in agony progressed to an inability  
10 to walk, inability to stand, inability to dress herself, inability to talk, and inability to control  
11 her bodily functions. Piper's altered mental state progressed from unusual thoughts to  
12 confusion, disorientation, then delirium, seizures, foaming at the mouth, and coma. Despite  
13 all of these observable symptoms of obvious distress, jail deputies and nurses confided to the  
14 medics, who eventually found Piper on the floor of her cell unresponsive, soaked in urine,  
15 and foaming at the mouth, that Piper was faking her symptoms or experiencing a "psych"  
16 issue.

Defendants were deliberately indifferent to Piper's obvious pain and suffering. Records from the Snohomish County Jail establish that Defendants attributed her obvious medical symptoms to disobedience or non-emergent mental health issues. Instead of providing treatment or care, they acted with disdain and punished her.

Defendant's deliberate indifference to Piper's serious medical need was the direct and proximate cause of days of grievous, unnecessary, and inhumane suffering that preceded her death.

II.

## PARTIES

26       2.1 Plaintiff Paulette Beck is a resident of Island County, Washington. She is the  
27 Personal Representative of Piper Travis' estate. Paulette is Piper Travis' biological aunt.  
28 Upon the tragic death of Piper's mother (when Piper was 2-years-old), Paulette and her

1 husband, Greg Beck, became Piper's parents. Paulette and Greg assumed sole custody of,  
2 guardianship over, and all parental duties and responsibilities for Piper. Paulette and Greg  
3 Beck had significant involvement in the life of Piper Travis at the time of this incident and  
4 Piper's death. Paulette brings claims individually (along with her husband/father of Piper,  
5 Greg Beck, and daughter/sibling of Piper, Tamara Cash, who also bring individual claims)  
6 and as Personal Representative for the Estate of Piper Travis.

7       2.2     Piper Travis was a long-time resident of Whidbey Island. The home she owned  
8 and lived in was mere minutes away from her parents' home. She was 34-years-old when she  
9 became critically ill while housed at the Snohomish County Jail on misdemeanor charges. As  
10 a direct result of Defendants' ignoring Piper's serious medical needs, Piper died on  
11 December 17, 2017. At all relevant times, Piper was a citizen of the United States, living in  
12 Island County, and as such was entitled to all rights, privileges, and immunities guaranteed  
13 under state law, federal law, and the Washington State, and U.S. Constitutions. Piper Travis  
14 has no surviving spouse or children.

15       2.3     At all material times, defendant Snohomish County was a municipal  
16 corporation organized under the laws of the State of Washington, which by and through its  
17 agency, the Snohomish County Sheriff's Office ("SCSO"), operated, managed and controlled  
18 the Snohomish County "Oakes Street" Jail ("SCJ") and employed, engaged and/or contracted  
19 with the remaining named defendants. Snohomish County is a public body responsible under  
20 state law for the acts and omissions of its employees, officials, and contractors, including  
21 those whose conduct is at issue in this action.

22       2.4     At all material times, defendant Ty Trenary ("Sheriff Trenary"), who is sued in  
23 his official capacity, was employed by Snohomish County as the elected Sheriff for  
24 Snohomish County and acting under color of law. In his role as Snohomish County Sheriff,  
25 Defendant Trenary is responsible for the operation, administration, and management of SCSO  
26 and SCJ, including formulating and implementing SCSO's policies and procedures,  
27 appointing top management, and ensuring that his deputies are properly and adequately  
28

1 trained. Additionally, it is his responsibility to evaluate SCSO employee conduct, investigate  
2 allegations of misconduct, and impose discipline when warranted.

3       2.5 At all material times, defendant Magellan Anderson (“Deputy Anderson”) was  
4 employed by Snohomish County as a corrections deputy, whose duties and responsibilities  
5 included providing for the custody and care of inmates, including monitoring inmates’ mental  
6 and physical health. At all relevant times, Deputy Anderson was acting under color of law  
7 and within the course and scope of his employment.

8       2.6 At all material times, defendant Emerson Yabut (“Deputy Yabut”) was  
9 employed by Snohomish County as a corrections deputy, whose duties and responsibilities  
10 included providing for the custody and care of inmates, including monitoring inmates’ mental  
11 and physical health. At all relevant times, Deputy Yabut was acting under color of law and  
12 within the course and scope of his employment.

13       2.7 At all material times, defendant Conner Smith (“RN Smith”) was licensed in  
14 Washington as a registered nurse and employed by Snohomish County as a nurse at SCJ. His  
15 duties and responsibilities included performing nursing assignments, conducting “fit-for-jail”  
16 assessments, assuring that immediate inmate health care needs are met, and coordinating  
17 appropriate follow-up care. At all material times, RN Smith was acting under color of law  
18 and within the course and scope of his employment.

19       2.8 At all material times, defendant Bik-Yee Urban (“RN Urban”) was licensed in  
20 Washington as a registered nurse and employed by Snohomish County as nurse at SCJ. Her  
21 duties and responsibilities included performing nursing assignments, conducting “fit-for-jail”  
22 assessments, assuring that immediate inmate health care needs are met, and coordinating  
23 appropriate follow-up care. At all material times, RN Urban was acting under color of law  
24 and within the course and scope of his employment.

25       2.9 At all material times, defendant Karin Heusted (“ARNP Heusted”) worked as  
26 an Advanced Registered Nurse Practitioner employed by Snohomish County at SCJ. Her  
27 duties and responsibilities included, in addition to normal nursing duties, acting as a  
28 “provider” at the jail, acting as a supervisor, and the responsibility for deciding when an

1 inmate should be transferred to a hospital for medical care. At all material times, she was  
2 acting under color of state law and within the normal course and scope of employment.

3       2.10 At all material times, defendant Jason Burns (“MHB Burns”) worked as a  
4 Mental Health Professional (“MHP”) employed by Snohomish County at SCJ. His duties and  
5 responsibilities included performing mental health and suicide assessments, placing or  
6 removing special watches, assuring that immediate mental health care needs are met, that risk  
7 for self-harm is protected against, and coordinating appropriate specialized follow-up care.  
8 At all material times, MHP Burns was acting under color of law and within the scope of his  
9 employment.

10      2.11 At all material times, Defendant Stuart Andrews, M.D., was licensed in  
11 Washington State as a physician and was employed by and/or under contract with Snohomish  
12 County to provide physician and medical director services to Snohomish County for the  
13 benefit of inmates of the SCJ. Dr. Andrews’ duties included, but were not limited to the  
14 following: on site consultation, examination of inmate/patients and/or chart review, orders  
15 for medications, labs, or other treatment for management of medical conditions; evaluations  
16 of inmates with chronic or medically complex conditions; consultation by phone with SCJ  
17 practitioners to determine need for hospitalization, medication changes, or other treatment for  
18 serious medical conditions; reviewing and approving medical policies and clinic protocol,  
19 including identifying the need for new protocols; reviewing medical services provided by  
20 nursing staff; and issuing standing orders for medication and treatment. At all relevant times,  
21 Dr. Andrews was acting within the course and scope of his employment with/for Snohomish  
22 County.

23      2.12 At all material times, Defendant Health Pros Northwest (“HPN”), a for-profit  
24 corporation organized and licensed under the laws of the State of Washington, contracted  
25 with Snohomish County to provide licensed, qualified, trained, experienced, and otherwise  
26 appropriate nursing and healthcare personnel to meet SCJ’s supplemental staffing needs. The  
27 contract between HPN and Snohomish County assigns HPN the right to direct and control  
28 HPN’s activities in providing these services. The contract also required the County to inform

1 HPN of all SCJ policies and procedures. At all relevant times, RNs Dunham and King were  
2 working at SCJ under HPN's contract with Snohomish County.

3       2.13 At all material times, defendant Jeanne Dunham ("RN Dunham") was licensed  
4 in Washington as a registered nurse and employed by HPN under its contract with Snohomish  
5 County to provide supplemental nursing staff at SCJ. Her duties and responsibilities included  
6 performing nursing assignments at SCJ, conducting "fit-for-jail" assessments, assuring that  
7 immediate inmate health care needs are met, and coordinating appropriate follow-up care.  
8 At all material times, RN Dunham was acting under color of law and within the course and  
9 scope of her employment.

10      2.14 At all material times, defendant Joseph King ("RN King") was licensed in  
11 Washington as a registered nurse and employed by HPN under its contract with Snohomish  
12 County to provide supplemental nursing staff at SCJ. His duties and responsibilities included  
13 performing nursing assignments at SCJ, conducting "fit-for-jail" assessments, assuring that  
14 immediate inmate health care needs are met, and coordinating appropriate follow-up care.  
15 At all material times, RN King was acting under color of law and within the course and scope  
16 of her employment.

17      2.15 Defendant JOHN DOES 1–10 are presently unidentified persons who, while  
18 acting under color of state law and within the normal course and scope of employment, were  
19 directly or indirectly responsible for the supervision and care of Piper Travis during her  
20 incarceration at SCJ between November 20, 2017 and December 1, 2017.

21      2.16 On April 26, 2019, Washington Governor Jay Inslee signed into law Substitute  
22 Senate Bill 5163, which became effective July 28, 2019. Sections 1-5 of that Act expand the  
23 claims that can be made under Washington law with respect to deceased persons. Section 6  
24 of that Act states: "This act is remedial and retroactive and applies to all claims that are not  
25 time barred, as well as any claims pending in any court on the effective date of this section."

26      2.17 Pursuant to that Act, Plaintiff Paulette Beck as Personal Representative and  
27 Plaintiffs Paulette and Greg Beck and Tamara Cash together and individually, bring wrongful  
28 death and survivor claims for damages on behalf of Piper Travis, Paulette Beck (Piper's

1 mother), Greg Beck (Piper's father), and Tamara Cash (Piper's sibling), all of whom are  
2 statutory beneficiaries as defined by the newly applicable language in RCW 4.20.020.  
3 Plaintiffs claim all damages available under the newly applicable language in RCW  
4 §§ 4.20.010, 4.20.020, 4.20.060, 4.20.046, and 4.24.010.

5

### 6 III.

7

#### 8 JURISDICTION AND VENUE

9

10 3.1 This is a civil rights deprivation of rights claim under the scope of 42 U.S. Code  
11 § 1983. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 1343, and 1367.

12

13 3.2 Venue is appropriate in the Western District of Washington pursuant to  
14 28 U.S.C. § 1391 because Defendant Snohomish County resides in this judicial district and  
15 the acts and omissions giving rise to the claims alleged herein occurred in Snohomish  
16 County, Washington, within the Western District of Washington.

17

18 3.3 Plaintiff Paulette Beck served a Notice of Tort Claim on the Snohomish County  
19 Risk Management Office on April 9, 2018 pursuant to RCW 4.92 et seq., and more than the  
20 required sixty (60) days has passed without resolution of the claim.

### 21 IV.

22

#### 23 FACTS

24

##### A. Deliberate Indifference to Piper's Pain, Suffering, and Serious Medical Needs

25

26 4.1 On the afternoon of November 20, 2017, an officer pulled over the car that  
27 Piper Travis was riding in because the driver did not have his seat belt on. When the officer  
28 discovered that Piper had some older misdemeanor warrants, she was arrested and booked  
into the Snohomish County Jail.

4.2

When Piper was booked into SCJ, RN Smith measured Piper's vital signs as follows:

Blood pressure sitting	114/69
Pulse sitting	87
Respiration	16

Temperature	98.2
Blood oxygen saturation	100

Based on this and other information, Jail staff found that Piper was “fit” for booking.

4.3 On the morning of November 21, 2017, Piper made an in-custody court appearance. She pled not guilty to misdemeanor charges and was held on an appearance bond, awaiting trial under the presumption of innocence. During the hearing, Piper conducted herself appropriately, answered questions rationally, and gave no indication whatsoever of illness or medical distress.

4.4 Between November 21 and November 28, SCJ records reveal few entries regarding Piper. Those entries that do reference her predominantly address how she spent the one hour per day of “rec time” during which she was allowed out of her solitary confinement cell.

4.5 On November 28, as her illness became obvious, Piper began to make regular appearances in SCJ’s record keeping system.

4.6 On November 28 at approximately 4:47 a.m., Deputy Munson noticed Piper “crying in her cell.” When asked what was wrong, Piper reported that she was suffering from a “terrible headache” with an “uncommon level of pain.”

4.7 In response to these observations, Deputy Munson summoned medical staff to visit and evaluate Piper.

4.8 When Defendant Conner Smith (“RN Smith”), a Jail nurse, responded, Piper told him that she did not have a history of migraine headaches and that the pain level was uncommon. Piper also made the odd comment that the pain may have been the result of “sabotage” by other inmates.

4.9 Despite Piper’s irrational thought process and report of an uncommonly painful headache, with no history or injury to explain it, it appears that RN Smith failed to conduct any meaningful medical assessment. No records were reviewed. No medical history was obtained. Nothing indicates that RN Smith even bothered to take Piper’s vital signs, which consist of clinical measurements of a person’s temperature, pulse rate, respiration rate, and

#### FIRST AMENDED COMPLAINT FOR DAMAGES

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1 blood pressure. Without scheduling any follow-up assessment or treatment and with no plan  
2 to check on Piper later, RN Smith simply issued Piper one dose of 400 mg of Ibuprofen and  
3 departed.

4 4.10 After RN Smith departed, Deputy Munson noted that, Piper “continued to make  
5 noises of pain and anguish for hours.” In response to Piper’s obvious pain and suffering,  
6 Deputy Munson ordered Piper to quiet down. In SCJ records, Deputy Munson wrote,  
7 “I reminded her [Piper] that she is sharing a small living space with 12 other women who are  
8 trying to sleep. Noise dropped off considerably for the time being.”

9 4.11 Later, on November 28, Ms. Travis “refused” rec time due to her headache.  
10 She later declined a meeting with her lawyer and lunch.

11 4.12 On November 28 at 1:18 p.m., Ms. Travis was noted to be “hard to rouse from  
12 sleep” when visited by Jail Classifications Officer Leopold.

13 4.13 On November 29 at 7:13 a.m., Defendant Yabut (“Deputy Yabut”) noted that  
14 Piper was “making strange noises” and was “very slow to process” instructions, which had to  
15 be repeated on “numerous” occasions “before she would comply.”

16 4.14 Deputy Yabut disciplined Piper by revoking her rec time “due to her incoherent  
17 behavior” and “inability to follow instructions.”

18 4.15 On November 29 at 3:15 p.m., Defendant Anderson (“Deputy Anderson”)  
19 noted on a SCJ record that Piper “refused” to return her meal tray. Deputy Anderson  
20 interpreted this event as insubordination and disciplined Piper by ordering that she receive  
21 sack meals for three days “as a deterrent.” In the same entry, Defendant Anderson noted that  
22 Piper “had been moaning sporadically all day.”

23 4.16 On November 30 at 6:22 a.m., Deputy Yabut noted that Piper “refused” to eat  
24 breakfast.

25 4.17 On November 30 at 6:51 a.m., Deputy Yabut noted that Piper had removed her  
26 pants. He recorded that when she (Piper) “is not sleeping, she is screaming.”

27 4.18 On November 30 at 3:00 p.m., Deputy Anderson noted that Piper, “had feces on  
28 her hands, her uniform, and upon the wall in her cell.” While ordering the disoriented Piper to

1 disrobe and clean herself, Deputy Anderson noted that she “shuffled aimlessly” and “at a  
2 slow speed,” seemed to have great difficulty dressing herself, and that she “refused” another  
3 visit with her attorney.

4       4.19 After observing Piper’s confusion and inability to read numbers written in large  
5 font on a piece of paper, Deputy Anderson callously wrote that, “MAX[imum confinement] is  
6 a good place for her.”

7       4.20 On November 30 from 4:00 p.m. through midnight, SCJ’s E unit was under the  
8 supervision of Deputy Farrell. Despite having access to all of the earlier reports of Piper’s  
9 distress, Deputy Farrell failed to memorialize anything regarding Piper’s behavior or  
10 wellbeing, writing that, “[A]ll of the excitement happened on day shift. Nothing significant to  
11 report for swing shift. Have a safe night.”

12      4.21 On December 1 at midnight, E unit was turned over to the supervision of  
13 Deputy Guerrero, who performed three “welfare/module checks” within the first hour.  
14 Deputy Guerrero promptly noticed something seriously wrong with Piper:

15       [She] was exhibiting abnormal behavior. Partially unclothed from the waist  
16 down. During the first welfare check, I knocked on her cell door and asked her  
17 to put her pants on. [Ms.] Travis did not acknowledge me. I knocked on the  
18 door several more times, [Ms.] Travis would not look directly at me. Her eyes  
19 would sort of roll back halfway, clenched fists, tensed body, shaking, breathing  
20 fast, yelling, and incoherent. She looked like she was in pain, but since she  
wasn’t talking. I really did not know where she stood. I know she is incoherent  
and slow to process directives/information but I had a weird feeling about her  
well-being.

21       After making these observations, Deputy Gurerro requested medical attention for  
22 Piper.

23      4.22 On December 1 at 1:15 a.m., Defendant Jeanne Dunham (RN Dunham),  
24 a “contract” nurse supplied to SCJ by Health Pros Northwest (“HPN”), responded to E unit to  
25 evaluate Piper. RN Dunham noted that Piper was screaming, “urinating on herself,” and her  
26 cell had the “smell of urine and feces.” RN Dunham noted that Piper, “will look at you when  
27 you call her name but will not answer.”

1       4.23 RN Dunham failed to take any of Piper's vital signs. She claims that she  
2 "tried" to measure Piper's blood oxygen saturation but was unable to do so because Piper  
3 would not "cooperate." In essence, RN Dunham conducted no meaningful medical  
4 assessment, conducted no type of records review nor collected any clinical information about  
5 Piper.

6       4.24 On December 1 at 1:29 a.m., RN Dunham departed E unit, leaving her severely  
7 ill patient with no plan to follow-up with her or attempt further assessment. Despite observing  
8 Piper's alarming symptoms, and despite having access to the earlier reports about Piper's  
9 rapidly deteriorating condition, RN Dunham failed to provide Piper any medical treatment.

10      4.25 On December 1, following her visit with Piper and without conducting any  
11 meaningful medical assessment, RN Dunham concluded that Piper's symptoms were  
12 behavioral in nature, as opposed to medical. Instead of placing Piper in the jail's medical unit,  
13 RN Dunham ordered that deputies transport Piper to the jail's Observation Unit for a  
14 "behavioral"—as opposed to a "medical"—watch and scheduled her for an appointment with  
15 a Jail Mental Health Provider.

16      4.26 No attempt was made by RN Dunham to identify, describe, or explain what  
17 mental health condition Piper apparently suffered from that would account for the symptoms  
18 that she objectively manifested, including suffering from severe pain, inability to walk,  
19 inability to talk, seizures, and incontinence. No effort was made to review or obtain a medical  
20 or mental health history. No effort was made to obtain any necessary records or contact any  
21 person or entity to gather additional necessary information.

22      4.27 On December 1, at 2:08 a.m., jail surveillance video shows Deputies Gurerro,  
23 Lewis, Mount, and Balentine carrying a non-ambulatory Piper down the E unit stairs to a  
24 wheelchair for transport to the Observation Unit. Deputy Gurerro noted that "[t]hroughout  
25 this process, [Ms.] Travis continued tensing up her body . . . like she was in pain and she  
26 wanted us to be aware of that." Apparently, no one questioned what possible (unnamed)  
27 mental health condition caused Piper to lose the ability to walk or stand.

1           4.28 The “behavioral” watch, which required jail deputies (as opposed to medical  
 2 professionals) to observe and record their observation of Piper every 30 minutes (on a Special  
 3 Watch form), began at approximately 2:30 a.m. on December 1:

TIME	DESCRIPTION OF MS. TRAVIS	BY DEPUTY
2:20 a.m.	“Seen by nurse”	[unknown]
2:30 a.m.	“Yelling”	Gomez
3:00 a.m.	“Screamed”	Gomez
3:30 a.m.	“On bunk, appears asleep”	Gomez
4: 00 a.m.	“On bunk, appears asleep”	Gomez
4:30 a.m.	“On floor, yelling”	Standish
5:03 a.m.	“Laying on floor, making noises”	Gomez
5:30 a.m.	“Refused breakfast”	Gomez
6:02 a.m.	“Laying on floor, awake”	Gomez
6:30 a.m.	“Laying on floor, awake”	Gomez
7:00 a.m.	“Laying on floor, awake”	Gomez
7:30 a.m.	“On floor, making noises”	Gomez

19           4.29 There are no entries whatsoever on the Special Watch log for the entire eight  
 20 hour “day shift” from 8:00 a.m. through 4:00 p.m. No SCJ record provides any explanation  
 21 for deputies’ failures to log or record their observations of Piper for this eight-hour period.

22           4.30 At 10:30 a.m., Defendant Jason Burns, a Jail mental health professional (“MHP  
 23 Burns”), visited Piper and described her condition as follows (emphasis added):

24           [*I*] observed [*her*] **writhing on the floor** near the door wearing standard issue  
 25 jail uniform. [*Her*] cell was highly malodorous and it appears that [*she*] urinated  
 26 on the cell floor. DOD was notified of [*the need to cleanup her*] cell situation.  
 27 This writer attempted to interview [*her*] for 10 minutes however [*she*] did not  
 28 respond to attempt to start a conversation. [*She*] yelled out a few times  
 appearing possibly in pain but did not respond to this writer. [*She*] made no eye  
 contact with this writer and was staring at the ceiling in her cell. [*She*] appears

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1 decompensated at this time and it appears that **the 30' watch is necessary to**  
 2 **confirm her safety while in custody.** Plan at this time is to continue the 30'  
 3 watch. [She] will remain in OU until baseline is established or behavior  
 changes. MHP will follow up tomorrow.

4       4.31 Defendant Bik-Yee Urban ("RN Urban"), a Jail nurse, accompanied MHP  
 5 Burns during his visit. RN states that she was unable to take Piper's vital signs during this  
 6 visit. She did not provide any other medical treatment. No attempt was made by MHP Burns  
 7 or RN Urban to identify or explain what mental health condition Piper apparently suffered  
 8 from that would account for all of the symptoms that she objectively manifested, including  
 9 suffering from severe pain, inability to walk, inability to talk, and incontinence. No evidence  
 10 suggests that either attempted a medical or mental health history, reviewed or attempted to  
 11 obtain any necessary records, or contacted any person to gather additional necessary  
 12 information.

13       4.32 On December 1 at 4:22 p.m., ARNP Heusted scheduled the first medical  
 14 appointment for Piper. The appointment was scheduled for December 4<sup>th</sup>, four days later.

15       4.33 Entries in the Special Watch Log resumed with the change of shift at 4:00 p.m.  
 16 (emphasis added):

TIME	DESCRIPTION OF MS. TRAVIS	DEPUTY
4:00 p.m.	"Laying on floor"	Rizk
4:40 p.m.	"Moved"	Rizk
5:10 p.m.	"Moved"	Rizk
5:25 p.m.	"Refused dinner"	Rizk
6:05 p.m.	<b>"On floor, foaming"</b>	Rizk
6:30 p.m.	<b>"On floor, foaming"</b>	Rizk
7:00 p.m.	<b>"On floor, foaming"</b>	Rizk
7:40 p.m.	[illegible]	[illegible]
8:00 p.m.	<b>"On floor, foaming"</b>	Rizk

1           4.34 At 7:40 p.m. on December 1, RN King memorialized some of Piper's vital  
 2 signs (for the first time since booking):

Blood pressure sitting	168/77
Pulse sitting	147
Respiration	36
Temperature	[blank]
Blood oxygen saturation	88.0%

9           4.35 On December 1, at 7:48 p.m., RN King's chart note for Piper indicated that  
 10 (emphasis added):

11           Ms. Travis is [n]ot responding, having rapid eye movements. [F]oaming in  
 12 her mouth and hyperventilating, [and] has not been eating and drinking for  
 13 almost 20 hours. [P]upils round equal and reactive, left eye sensitive to light,  
 vital[s] elevated, [she is] unable to take oral meds and non verbal.

14           However, despite knowledge of Piper's vital signs and symptoms, RN neither  
 15 contacted 911 nor requested paramedics. Rather, Defendant King called a two-person EMT  
 16 team to respond to the jail to perform a standard "psych eval" on Ms. Travis.

17           4.36 In a chart note that she failed to enter until December 6, ARNP Heusted admits  
 18 that she had been informed by RN King about Piper's concerning condition. She documented  
 19 that RN King informed her that Piper had not been eating (or drinking), was not responsive or  
 20 talking, and had resisted vital signs. Heusted "ordered" continued observation. Hours later,  
 21 RN King again contacted Heusted to inform her that Piper did not look good and that a  
 22 deputy was "concerned." Heusted then agreed that RN King could have Piper assessed for  
 23 transport to the hospital.

24           4.37 In a chart note that he failed to enter until December 6, 2017, Dr. Stuart  
 25 Andrews states that on December 1, 2017 between 1630 and 1700 hours, RN King had  
 26 contacted him and reported that Piper Travis was on the floor writhing, which she had been  
 27 doing earlier. She (Piper) had been seen by nurses and MHPs and her presentation was  
 28 thought to be behavior. She (Piper) had been urinating on herself and the odor of feces was

1 reported; first noted at 0230. Dr Stuart noted that Piper had complained of a headache on  
2 November 28, 2017 but claimed that there were no further documented reports of headache.  
3 He noted that Piper had resisted vital sign checks by Nurse King. Without requesting or  
4 obtaining any additional information or visiting/directly observing/examining Piper Travis,  
5 Dr. Andrews declined to have Piper transported to an emergency room. Instead, he asked  
6 Nurse King to make frequent nursing checks, “and if her presentation did not change for the  
7 better in the next 2 hours, if it or (sic) declined, to call the provider on call for possible  
8 hospital transfer.”

9 4.38 RN King and ARNP Heusted and Dr. Andrews failed to declare a medical  
10 emergency for Piper, failed to contact 911, and failed to provide emergency medical care.  
11 Instead of contacting paramedics, they placed a non-emergency call to EMTs at 7:58 p.m.

12 4.39 By declining to declare a medical emergency for Piper, SCJ avoided having  
13 their SCJ employees (deputies and medical staff) write an incident report (as would have been  
14 required by law and policy).

15 4.40 On December 1, a two-person EMT team arrived at the Jail. The EMTs noticed  
16 that no one at the jail seemed particularly upset or worried about Piper, and no medical staff  
17 were present to greet them or provide any medical history or assessment of Piper. Jail  
18 employees again informed the EMTs that Piper just needed a “psych eval,” and they  
19 suggested to the EMTs that Piper was “faking it.”

20 4.41 Upon encountering Piper, the EMTs immediately recognized that she was  
21 extremely ill. They described Piper lying supine on a mattress in her own urine, unresponsive  
22 to verbal stimuli and hyperventilating with frothy white sputum around her mouth. They  
23 observed Piper suffering seizure activity, including involuntary movement of her arms and  
24 recorded her temperature at 102 degrees. Jail staff informed the medics that Piper had been  
25 in that condition for at least four hours.

26 4.42 The EMTs decided that Ms. Travis’ condition was far too critical to call 911  
27 and wait for paramedics. They decided to immediately transport Ms. Travis to the hospital,  
28 using emergency lights and sirens.

1       4.43 On their paperwork, the EMTs checked the box for “possible neglect”  
 2 associated with Ms. Travis’ condition.

3       4.44 On December 1 at 8:32 p.m., the EMTs and Ms. Travis arrived at Providence  
 4 Regional Medical Center Everett, whose medical professionals were again able to measure  
 5 Ms. Travis’ vital signs:

Blood pressure sitting	142/92
Pulse	147
Respiration	32
Temperature	101.5 F
Blood oxygen saturation	98.0%

12      She was diagnosed with sepsis, meningitis, and acute respiratory distress. They noted:  
 13     “Distress: severe” and Ms. Travis is “critically ill appearing.”

14      4.45 Doctors heavily dosed Ms. Travis with painkillers and antibiotics, medically  
 15 inducing a coma that finally relieved her of the pain and suffering inflicted by Defendants’  
 16 deliberate indifference.

17      4.46 Defendant’s failed to notify anyone from Ms. Travis’ family about her  
 18 circumstances until December 5, 2017, four days after her arrival at the hospital.

19      4.47 Ms. Travis’ family is haunted by the thought of Ms. Travis struggling and  
 20 suffering alone, first in her cell and then at the hospital, with no loved ones to support her.

21      4.48 On December 12, 2017, having stabilized her condition but with no brain  
 22 activity, doctors urged Ms. Travis’ family to put her on palliative care and remove life  
 23 support.

24      4.49 On December 14, 2017, with no improvement in her condition, Ms. Travis’  
 25 family agreed.

26      4.50 On December 15, Ms. Travis underwent music-thanatology therapy. She  
 27 “responded to lullabies played in the rhythm of her breathing, with a slight decrease in rate  
 28 and several sighs.”

1       4.51 On December 16, less than one month after being booked into the Snohomish  
2 County Jail on misdemeanor charges, Ms. Travis died.

3       **B. Deliberate Indifference of Sheriff Trenary, Snohomish County, and HPN  
4 Resulting From SCJ's Inadequate Policies, Practices, Customs, and Systemic  
5 Deficiencies.**

6       4.52 There is a long, concerning pattern of inmate deaths at the Snohomish County  
7 Jail. Beginning in 2014, prompted by an unusual number of deaths, SCSO was the focus of a  
8 number of reviews and assessments that were highly critical of SCSO's operation and  
9 management of SCJ. These reviews were conducted by the Pierce County Sheriff's Office,  
10 the National Institute of Corrections ("NIC"), and a consultant hired by SCSO. The reviews  
11 resulted in a number of recommendations to Sheriff Trenary and SCSO that were necessary in  
12 order to bring their operations up to a constitutionally sufficient level.

13       4.53 In August 2013, Pierce County officials met with SCJ officials to discuss their  
14 review and assessment of SCJ's operations. The minutes from the meeting reveal that Pierce  
15 County officials warned Snohomish County, in part, that: "There are no intervention efforts  
16 being undertaken or conducted. A common fallback to accommodate shortfalls for staffing  
17 and care is that the inmate is tagged as "feigning" their need for care. This then becomes part  
18 of the "culture" as is the case for the [SCJ].

19       4.54 Over the last few years, Snohomish County has faced an uncommon number of  
20 lawsuits arising from their repeated deliberate indifference to the medical and mental health  
21 needs of the inmates housed at SCJ. Reports from numerous experts have been provided to  
22 Sheriff Trenary and SCJ administration that identify the clear need for increased employee  
23 accountability, additional training, and improved policy and procedure. The lawsuits have  
24 identified a clear pattern or series of incidents of deliberate indifference to inmates' serious  
25 medical and mental health needs. Although the lawsuits have resulted in numerous costly  
26 settlements that have required Snohomish County and those persons it contracts with to pay  
27 millions of dollars, Sheriff Trenary and his SCJ administration have failed to address their  
28 deficiencies.

1       4.55 In purposeful defiance of the damning conclusions of the formal reviews and  
2 assessments, and of the hefty settlement figures, Sheriff Trenary and his selected SCJ  
3 administrators have consistently ratified the actions of SCJ employees who violate the  
4 constitutional rights of inmates. Sheriff Trenary fails to discipline SCJ employees' deliberate  
5 indifference to an inmate's serious medical or mental health need. This continual ratification  
6 has sent a clear message to SCJ employees that their actions are beyond meaningful review  
7 and accountability. Sheriff Trenary's failure of leadership and accountability has created an  
8 institutional culture that not only tolerates, but supports, ignoring and doubting inmates'  
9 serious medical needs and actively obstructs the provision of adequate medical care.

10      4.56 In the present case, Sheriff Trenary not only failed to discipline anyone for what  
11 happened to Piper, he has taken his culture of ratifying constitutional violations to a new low.  
12 He has regressed from simply ignoring the conclusions of formal reviews of his employees'  
13 actions to, now, refusing to conduct any review at all. He relies on the fact that SCJ  
14 transported a comatose and unresponsive Piper Travis to the hospital before she died to  
15 support his position that no investigation into the actions of his employees or circumstances  
16 surrounding her death is warranted or necessary.

17      4.57 To date, no investigation (death, internal, or otherwise) has been conducted into  
18 the circumstances leading to Piper's death. Snohomish County has steadfastly ignored  
19 Plaintiff's (and her attorneys') request for any type of investigation. This refusal to  
20 investigate has been coupled with SCSO failing to timely respond to Plaintiff's public  
21 records requests. For example, nearly one year ago, Plaintiff submitted a request for jail  
22 surveillance video depicting Piper while she was housed at SCJ. To date, SCSO has failed to  
23 produce a single video clip of Piper Travis to Plaintiff, asserting that all of the video is  
24 confidential and claiming that they are still working on necessary "redactions" of the video.

25      4.58 Sheriff Trenary's refusal to investigate his employees' actions relating to  
26 Piper's death is a cagey and self-serving attempt to avoid knowledge of his employees'  
27 actions, inactions, and failings. His failure to investigate, supervise, and impose  
28

1 accountability constitutes an institutional and official deliberate indifference to inmates'  
2 rights

3        4.59 The circumstances of this case evidence a continued pattern and practice of  
4 inmates' serious medical needs being ignored as a result of an accepted custom and culture of  
5 SCJ employees' assuming that inmates are faking or feigning their medical or mental health  
6 symptoms.

7       4.60 Sheriff Trenary and Snohomish County continue to operate the SCJ with  
8 inadequate policy and procedure. For example, at the time of Piper Travis's death, nothing  
9 indicates that there was policy, procedure, or training related to how frequently an inmate's  
10 vital signs must be taken, what steps a medical provider should take if any inmate refuses to  
11 have his/her vital signs taken, and/or recording or tracking an inmate's intake of food and  
12 fluids.

13        4.61 According to the contract between Snohomish County and HPN, HPN adopted  
14 and/or ratified all SCJ policies, practices, and procedures (or lack thereof). HPN agreed to be  
15 informed of SCJ policy and procedure. It also agreed that its employees would operate under  
16 existing SCJ policy and procedure while working at SCJ.

V.

**FIRST CAUSE OF ACTION: SECTION 1983 –  
FOURTEENTH AMENDMENT VIOLATION – DELIBERATE  
INDIFFERENCE TO PIPER TRAVIS’S SERIOUS MEDICAL NEED**

5.1 Jail inmates have the constitutional right to receive and access adequate health care. The rights of pretrial detainees, such as Piper Travis, emanate from the Due Process Clause of the Fourteenth Amendment.

24        5.2 By virtue of the facts set forth above, the Defendants violated Piper Travis's  
25 federally-protected rights by their deliberate indifference to her pain, suffering, and serious  
26 medical need. As a direct and proximate result of the defendants' deliberate indifference to  
27 Piper's constitutional rights, Piper suffered gruesome pre-death pain, suffering, terror, and  
28 anxiety, in an amount to be proven at trial.

5.3 By virtue of the facts set forth above, Defendant Snohomish County and its agents and employees and Defendant Trenary interfered with, obstructed, and otherwise deprived Piper Travis of her constitutionally protected Civil Rights, including, but not limited to, the violation of Piper's right to due process and equal protection of the laws protecting those similarly situated as her, including her liberty interests and protection of her life; the violation of Piper's right against cruel and unusual punishment and for the deliberate indifference to Piper's right to reasonable, effective, and prompt medical care and treatment.

5.4 By virtue of the facts set forth above, Defendant Snohomish County was aware of the inadequate medical care SCJ was providing to its inmates and failed to adequately train, supervise, and hold accountable its employees with regard to the conduct described herein. Defendant Snohomish County deprived Piper Travis of her civil rights and her entitlement to equal protection of the law via its lack of training, policies, and procedures, which have directly led to multiple deaths at the Snohomish County Jail, including but not limited to deliberate indifference, lack of proper observation, missed watches, lack of medical screening, and lack of necessary medical treatment, all in violation of 42 U.S.C. § 1983.

5.5 Additionally, by virtue of the facts set forth above, the Defendants are liable for compensatory and punitive damages for deprivation of the civil rights of Piper Travis guaranteed by the Fourteenth Amendment to the Constitution and 42 U.S.C. § 1983 to be free from deprivation of life without due process of law.

VI.

**SECOND CAUSE OF ACTION: SECTION 1983 CIVIL  
RIGHTS VIOLATION FOURTEENTH AMENDMENT RIGHTS –  
LOSS OF PARENT CHILD RELATIONSHIP**

6.1 Parents have long been recognized as having standing to sue for their own losses associated with the wrongful death of a child by officials under 42 USC 1983. Parents have a constitutionally protected liberty interest under the Fourteenth Amendment in the love, companionship and relationship with their child.

1       6.2 By virtue of the facts set forth above, the Defendants, through their deliberate  
2 indifference, caused Plaintiffs Paulette and Gregory Beck, who became Piper's parents at the  
3 age of two and remained her parents until her death, to be deprived of their constitutional  
4 right to love, society and companionship with their daughter, Piper, for which they are  
5 entitled to compensatory and punitive damages in an amount to be proved at trial.

VII.

### **THIRD CAUSE OF ACTION – STATE LAW CLAIM - OUTRAGE (State Law Claim – Outrage)**

7.1 By virtue of the facts set forth above, Defendant Snohomish County and Defendant Trenary are liable to the Plaintiffs for the tort of outrage because of the extreme and outrageous actions of its employees who failed to notify Piper's family of her medical emergency and/or transport to Providence Hospital. Piper's parents are haunted by the image of their daughter alone in her hospital room. For days, they were prevented from being with their dying daughter. They were deprived of the chance to comfort her. They were denied any chance to advocate for her health care needs. They were denied any opportunity to provide relevant information regarding her medical background. Worst yet, they were deprived of their final moments with Piper. They are outraged by the actions of SCJ that led to their daughter being all alone, fighting for her life because no one at SCJ made any attempt to contact them.

VIII.

## **FOURTH CAUSE OF ACTION FOR WRONGFUL DEATH, SURVIVAL, AND DEATH OF CHILD CLAIMS UNDER WASHINGTON LAW**

8.1 By virtue of the facts set forth above, Defendants Snohomish County and Health Pros Northwest by and through the actions/inaction of their employees violated Washington State law. Said Defendants owed Piper Travis a duty of reasonable medical care during her incarceration at the SCJ. Defendants breached their duty, and treated Piper negligently and below the standard of care to which each is held. As a direct and proximate

1 result of their negligent conduct, Piper Travis experienced substantial pre-death pain, terror,  
2 suffering, anxiety, and eventual death. Additionally, the Defendants by and through their  
3 negligence caused Plaintiffs Paulette and Greg Beck, who became Piper's parents at the age  
4 of two and remained her parents until her death, and Piper's sibling, Tamara Cash, to be  
5 deprived of their constitutional right to love, society and companionship with their daughter  
6 and sister.

7       8.2 Plaintiffs claim all remedies available under RCW 4.20 et seq. and RCW 4.24  
8 et seq, as currently enacted July 28, 2019.

## VIII. REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request relief against Defendants as follows:

1. Fashioning an appropriate remedy awarding Plaintiffs general and special damages including damages for pain, suffering, terror, and loss of parental relationship pursuant to § 1983 and 1988 and any applicable Washington law;

2. Punitive damages from the individual, non-municipal, Defendants to the extent authorized by law in an amount to be proven at trial;

3. Awarding Plaintiffs reasonable attorney's fees and costs, under 42 U.S.C. § 1988 and to the extent otherwise permitted by law; and

4. For all damages sustained by plaintiffs in an amount proven at trial, including without limitations, all available noneconomic damages, including loss of life, incurred medical, funeral, and burial expenses, loss of consortium, loss of love, destruction of the parent-child-sibling relationship, and the pain, suffering, terror, anxiety and fear of impending death or their daughter and sister, decedent Piper Travis; and

5. Such other relief as may be just and equitable.

11

11

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DATED this 7<sup>th</sup> day of August 2019.

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